

Kearney Christopher L - Vol I

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

JEFFERSON-PILOT :
INSURANCE COMPANY, :
Plaintiff, :
vs. : Case No. C-1-02-479
CHRISTOPHER L. :
KEARNEY, :
Defendant. :

Videotaped deposition of CHRISTOPHER L.
KEARNEY, a defendant herein, taken by the
plaintiff as upon cross-examination, pursuant
to the Federal Rules of Civil Procedure and
pursuant to notice, agreement by counsel as
to the time and place and stipulations
hereinafter set forth, at the offices of
William R. Ellis, Wood & Lamping, 2500
Convergys Center, 600 Vine Street, Ohio, at
9:45 on June 20, 2007, before Deanne
Cartwright, a Court Reporter and Notary
Public within and for the State of Ohio.

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APPEARANCES

On behalf of Plaintiff:

JOHN E. MEAGHER, ESQ.
of

Shutts & Bowen LLP
1500 Miami Center
201 South Biscayne Boulevard
Miami, Florida 33131

On behalf of Plaintiff:

STEPHANIE FARABOW, ESQ. (Via telephone.)
of

Jefferson-Pilot Life Insurance Company
100 N. Greene
Greensboro, North Carolina 27401

On behalf of Plaintiff:

WILLIAM R. ELLIS, ESQ.
of

Wood & Lamping



Kearney Christopher L - Vol I

time on your claim?

MR. ROBERTS: Objection. Go ahead.

A. When DMS took over there was constant interaction, constant requests and I had, you know, previously from JP a few.

Q. And, in fact, you signed

releases with regard to obtaining payment of your benefits --

MR. ROBERTS: Objection.

Q. -- correct?

MR. ROBERTS: Objection. Go ahead.

A. When you say releases, what do you mean, two different releases or one?

Q. Well, let's start broad. Any releases. Did you sign any releases with regard to the insurer's and DMS's ability to investigate your claim?

MR. ROBERTS: Objection. Misstating facts as to release of claims. Go ahead.

A. I did sign a limited release with Jefferson-Pilot almost every month and then DMS forced me to sign a big broad general authorization by -- by refusing to pay my benefit until I signed it.

Q. So did you sign one?

MR. ROBERTS: Objection. Go ahead. Asked and answered.

A. I signed it under duress.

Q. Did you contact any lawyer to represent you at that time?

MR. ROBERTS: Objection. That requires attorney/client privilege.

Q. I'm not asking about any communication. I'm saying that since you felt you were under duress what steps, if any, did you take to protect yourself from such actions?

MR. ROBERTS: As he recalls today from 10 years ago?

MR. MEAGHER: Are you telling him not to remember, counsel? Please.

MR. ROBERTS: Did you hear me

Kearney Christopher L - Vol I
15 say that, counsel? I mean, your question
16 today in 2007 is the authorization he was
17 required to sign back in '97, '98 or is it
18 last month's authorization, which one? Do
19 you want a correct answer?

20 MR. MEAGHER: Do you have a
21 question? Do you have a question for me
22 because I don't have to answer his question
23 if he doesn't understand.

24 MR. ROBERTS: Okay. Well, your

0093
1 professionalism is noted on the record.

2 MR. MEAGHER: Yeah, I know that,
3 counsel. You said --

4 A. If you don't mind repeating.

5 Q. I'll repeat it. That's fine,
6 Mr. Kearney.

7 A. Sure.

8 Q. With regard -- you said you
9 signed a release under duress --

10 A. Yes.

11 Q. -- and I'm saying what actions,
12 if any, did you take to try to prevent that
13 from occurring?

14 A. I tried to contact
15 Jefferson-Pilot but they wouldn't take my
16 calls. They just referred me back to Robert
17 Mills. I did have an attorney that I was
18 speaking with to give me advice.

19 Q. Who was that?

20 A. I believe it was Clint Miller.

21 Q. So at the time of your signing
22 the DMS release you were represented by
23 Mr. Miller?

24 MR. ROBERTS: Objection.

0094
1 A. No.

2 MR. ROBERTS: That's not what
3 his testimony was. Go ahead.

4 A. No. I was not represented by
5 Mr. Miller. I consulted Mr. Miller.

6 Q. Okay. Let me hand you composite
7 Exhibit 1.

8 A. Okay.

9 Q. And could you please look
10 through that document --

11 MR. ROBERTS: Hold on. I want

Disability Insurance Claim

Jefferson-Pilot
Life Insurance Company
417 — Individual Health Division
PO Box 20727
Greensboro, NC 27420

**Jefferson
Pilot**

Claimant's Name CHRISTOPHER L. KEARNEY Age 43 Policy No. 1000000000 Telephone No. 336-330-0870 Social Security No. 123-45-6789

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 6-9, 1993 Claimant's Signature Christopher L. Kearney

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Attending Physician's Statement

1. Diagnosis and Concurrent Conditions (If code other than ICD-9, use ICD-10)

2. Date 2-4-93 3. Date patient commenced your care 4-30-93

4. Patient still under your care for this condition? ☒ Yes ☐ No 5. Did condition(s) arise out of patient's employment? ☒ Yes ☐ No

6. Dates of Services 4/30/93 - 6/14/93 (15 visits) 7. Patient ever had same or similar condition? ☒ Yes ☐ No (If "Yes", when and describe:)

11/27/89

8. Patient was continuously totally disabled (unable to work) From 2/5/93 Thru 2/8/93 9. Patient was partially disabled. From 2/8/93 Thru PRESENT DAY

10. If still disabled, date patient should be able to return to work. tentatively Aug. 1, 1993 11. Does patient have other health coverage? ☐ Yes ☐ No (If "Yes", please identify:)

UNKNOWN

12. Remarks the patient did not have any pain or other conditions since he was seen in 1989.

Date 6/14/93 Physician's Name (Print) Amberse S. Riddick, D.O. Signature Amberse S. Riddick, D.O. Degree Doctor of Chiropractic Telephone 336-330-0870

Street Address 11071 MAIN ST City or Town CINCINNATI State or Province OH Zip Code 45241

Employer's Statement

1. Employee's Name CHRISTOPHER L. KEARNEY Date Last at Work Part-time 19 Date Last at Work Full-time 19

2. Has employee returned to all of his or her work? (If "Yes" give date) 19 ☐ Yes ☐ No

3. Has he or she returned to part of his or her work? (If "yes", give date and list important duties employee is unable to perform.) Feb 9, 1993 Unable to spend as much time on job ☒ Yes ☐ No

4. Is he or she filing for Workmen's Compensation benefits? ☒ Yes ☐ No

5. Has employment with you been terminated? (If "Yes", give date and reason.) 19 ☐ Yes ☒ No

6. Does your firm pay any portion of the cost of this coverage? ☒ Yes ☐ No (If "Yes", what percent of premium 100 %)

3129

7. Is this coverage part of a Salary Reduction Cafeteria Plan? ☐ Yes ☒ No

KEARNEY ASSOCIATES, INC.

Name of Firm

Christopher L. Kearney
Signature and title of person completing this form

Date 6-9, 1993 Address

Telephone No.

WJ-291 Rev 7-90

*ICDA - I Classification of Diseases

EXHIBIT 1
Deponent Kearney
Date 6/20 Rptr. DC
WWW.DEPBOOK.COM

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

Date 8-9, 19 93 Claimant's Signature Christopher L. Keenan

SHARONVILLE CHURCH
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DR. AMBROSIO
(1951) (1952) (1953) (1954)
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Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 8.3., 19 93 Claimant's Signature Christine L. Kurney

2002 IN 0-2325
IN-100-100000

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Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 11-10-93 Claimant's Signature Christoph L. Kuehn

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Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 12-1 19 93 Claimant's Signature [Signature]

0984

Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date

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Claimant's Signature

Christopher L. Kennedy

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Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 3-30, 19 94 Claimant's Signature Christopher L. Riesing

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Disability Insurance Claim

Jefferson-Pilot
Life Insurance Company
417 — Individual Health Division
PO Box 20727
Greensboro, NC 27420

**Jefferson
Pilot**

Claimant's Name <u>CHRISTOPHER L. KEARNEY</u>	Age <u>41</u>	Policy No. <u>H538069</u>	Telephone No. <u>(513) 769-5441</u>	Social Security No. <u>14493029</u>
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Disclosure Authorization

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Date Oct 31, 1994 Claimant's Signature Christopher L. Kearney

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Attending Physician's Statement

1. Diagnosis and Concurrent Conditions (if code other than ICDA* used, give name and if pregnancy show E.D.C.) <u>Major depression, chronic & acute exacerbations; recent adjustment disorder</u>	
2. Date symptoms first appeared or accident happened. <u>11/93</u>	3. Date patient consulted you for this condition. <u>11/8/93</u>
4. Patient still under your care for this condition? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	5. Did condition(s) arise out of patient's employment? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6. Dates of Services <u>see printout</u>	7. Patient ever had same or similar condition? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes", when and describe) <u>no prior treatment though</u>
8. Patient was continuously totally disabled (unable to work) From _____ Thru _____	9. Patient was partially disabled. From <u>2/5/93</u> Thru <u>present</u>
10. If still disabled, date patient should be able to return to work. <u>uncertain presently</u>	11. Does patient have other health coverage? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No (If "Yes", please identify):
12. Remarks <u>on medical therapy + utilizing psychotherapy x 1 yr.</u> <u>- recent divorce</u>	

Date <u>10/26/94</u>	Physician's Name (Print) <u>M. LEHNER MD.</u>	Signature <u>[Signature]</u>	Degree <u>MD</u>	Telephone <u>308 3445</u>
Street Address <u>770 Reading Rd.</u>	City or Town <u>Mason, O.</u>	State or Province <u>43040</u>	Zip Code	

Employer's Statement

1. Employee's Name <u>CHRISTOPHER L. KEARNEY</u>	Date Last at Work Part-time _____ 19____	Date Last at Work Full-time _____ 19____
2. Has employee returned to all of his or her work? (If "Yes" give date _____, 19____)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
3. Has he or she returned to part of his or her work? (If "yes", give date and list important duties employee is unable to perform.) _____, 19____ <u>unable to work as effectively</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is he or she filing for Workmen's Compensation benefits?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
5. Has employment with you been terminated? (If "Yes", give date and reason.) _____, 19____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
6. Does your firm pay any portion of the cost of this coverage? (If "Yes", what percent of premium _____ %)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7. Is this coverage part of a Salary Reduction Cafeteria Plan?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	

Name of Firm KEARNEY ASSOCIATES INC. Signature and title of person completing this form Christopher L. Kearney, Pres.

Date _____, 19____ Address 12168 Village Woods Dr. Telephone No. (513) 769-5885

RCJ BY: XEROX TELECOPIER 7010 : 10-31-94 9:19AM :
 OCT 31 '94 07:47 KEARNEY ASSOCIATES
Insurance Claim
 Jefferson-Pilot
 Life Insurance Company
 417 - Individual Health Division
 PO Box 20727
 Greensboro, NC 27420

CCITT 634

9106914254: # 3

JEFFERSON-PILOT
 3/5

Claimant's Name CHRISTOPHER L. KEARNEY Age 41 Policy No. 4532069 Telephone No. (513) 769-5441 Social Security No. 14493029

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

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Date Oct 31, 1994 Claimant's Signature Christopher L. Kearney

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Attending Physician's Statement

1. Diagnosis and Concurrent Conditions (If code other than ICDA* used, give name and if pregnancy show E.D.C.)
Major depression, chronic & acute exacerbations; recent adjustment disorder
2. Date symptoms first appeared or accident happened. 11/93
3. Date patient consulted you for this condition. 11/93
4. Patient still under your care for this condition? ☒ Yes ☐ No
5. Did condition(s) arise out of patient's employment? ☒ Yes ☐ No
6. Dates of Services see plaintiff
7. Patient ever had same or similar condition? ☒ Yes ☐ No
 (If "Yes", when and describe): no prior treatment sought
8. Patient was continuously totally disabled (unable to work)
 From _____ Thru _____
9. Patient was partially disabled:
 From 2/93 Thru present
10. If still disabled, date patient should be able to return to work.
uncertain presently
11. Does patient have other health coverage? ☐ Yes ☒ No
 (If "Yes", please identify):
12. Remarks on medical therapy + utilizing psychotherapy x 1 yr.
- recent divorce

Date 10/26/94 Physician's Name (Print) M. LEHENEBAUER MD. Signature [Signature] Degree MD Telephone 390 3445
 Street Address 770 Reading Rd. Mason, O. City or Town Mason, O. State or Province OH Zip Code 43040

Employer's Statement

1. Employee's Name CHRISTOPHER L. KEARNEY Date Last at Work Part-time presently 19
 Date Last at Work Full-time presently 19
2. Has employee returned to all of his or her work? (If "Yes" give date _____, 19____) ☐ Yes ☒ No
3. Has he or she returned to part of his or her work? (If "yes", give date and list important duties employee is unable to perform.) _____, 19____ unable to work as effectively ☒ Yes ☐ No
4. Is he or she filing for Workmen's Compensation benefits? ☐ Yes ☒ No
5. Has employment with you been terminated? (If "Yes", give date and reason.) _____, 19____ ☐ Yes ☒ No
6. Does your firm pay any portion of the cost of this coverage? (If "Yes", what percent of premium _____%) ☐ Yes ☒ No
7. Is this coverage part of a Salary Reduction Cafeteria Plan? ☐ Yes ☒ No

KEARNEY ASSOCIATES INC.
 Name of Firm

Christopher L. Kearney, Pres.
 Signature and title of person completing this form

Date _____, 19____ Address 12168 Village Woods Dr. Telephone No. (513) 769-5822

WJ-291 Rev 7-90

*ICDA - International Classification of Diseases

0589

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 2/12/, 19 95 Claimant's Signature

Christopher L. Kearney

Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 5-1-, 19 95 Claimant's Signature Christopher L. Kurney

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Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date: 6-1, 1995 Claimant's Signature Christopher L. Kearney

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Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

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Date 7-13, 19 95 Claimant's Signature Christopher L. Kearney

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Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

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Date 8-4, 19 95 Claimant's Signature Christopher L. Klesny

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Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 9-11, 1995 Claimant's Signature Christopher L. Kearney

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Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 10/2, 1995 Claimant's Signature Christopher L. Kearney

80-11111 9-10096
111-111-11111

1005

Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 11/1, 19 95 Claimant's Signature Christopher L. Kennedy

69-1110 6-10073

1007

Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 12-1, 19 95 Claimant's Signature

Christopher L. Kearney

Dec-01-95 08:53A Kearney Associates, Inc. 513-769-0818

PAGE

Disclosure Authorization

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Date 12-1, 19 95 Claimant's Signature Christoph L. Kearney

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PAGE 03

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 1-2, 1996 Claimant's Signature Christopher Kearney

96 JAN -5 AM 10:22

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Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 2-2, 19 96 Claimant's Signature Christopher Kearney

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96 FEB -6 AM 10:47

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 3-4, 19 96 Claimant's Signature Christoph K. Kurny

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1015

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 4-3, 19 96 Claimant's Signature Christopher Kearney

96 APR - 8 AM 11:50

174-176-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098-1099-1100-1101-1102-1103-1104-1105-1106-1107-1108-1109-1110-1111-1112-1113-1114-1115-1116-1117-1118-1119-1120-1121-1122-1123-1124-1125-1126-1127-1128-1129-1130-1131-1132-1133-1134-1135-1136-1137-1138-1139-1140-1141-1142-1143-1144-1145-1146-1147-1148-1149-1150-1151-1152-1153-1154-1155-1156-1157-1158-1159-1160-1161-1162-1163-1164-1165-1166-1167-1168-1169-1170-1171-1172-1173-1174-1175-1176-1177-1178-1179-1180-1181-1182-1183-1184-1185-1186-1187-1188-1189-1190-1191-1192-1193-1194-1195-1196-1197-1198-1199-1200-1201-1202-1203-1204-1205-1206-1207-1208-1209-1210-1211-1212-1213-1214-1215-1216-1217-1218-1219-1220-1221-1222-1223-1224-1225-1226-1227-1228-1229-1230-1231-1232-1233-1234-1235-1236-1237-1238-1239-1240-1241-1242-1243-1244-1245-1246-1247-1248-1249-1250-1251-1252-1253-1254-1255-1256-1257-1258-1259-1260-1261-1262-1263-1264-1265-1266-1267-1268-1269-1270-1271-1272-1273-1274-1275-1276-1277-1278-1279-1280-1281-1282-1283-1284-1285-1286-1287-1288-1289-1290-1291-1292-1293-1294-1295-1296-1297-1298-1299-1300-1301-1302-1303-1304-1305-1306-1307-1308-1309-1310-1311-1312-1313-1314-1315-1316-1317-1318-1319-1320-1321-1322-1323-1324-1325-1326-1327-1328-1329-1330-1331-1332-1333-1334-1335-1336-1337-1338-1339-1340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Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 5-6, 19 96 Claimant's Signature Christopher Keating

2004-08-10 08:41:05

ATP-2004-08-10

Disclosure Authorization

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I or my authorized representative is entitled to receive a copy of this authorization.

Date 6-1, 1996 Claimant's Signature Christy John Kearney

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Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information; I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

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Date

8-4

1996

Claimant's Signature

Christopher Kearney

56 AUG -8 - AM 11:20

RECEIVED - JPL - 417

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 9-2, 19 96 Claimant's Signature Christopher Keeney

SEP 11 9-11-96

1035

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date

9-10-96

, 1996

Claimant's Signature

Christopher Kearney

56 OCT -7 AM 9:22

ATG-INT-NEWTON

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 12-3, 1996 Claimant's Signature Christopher Kearney

RECEIVED - JPI - 217
96-DEC-9 AM 10:46

1040

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 1-2, 19 97 Claimant's Signature Christopher L. Kearney

RECEIVED-IHI-417
97 JAN -6 AM 8:46

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 1-31, 19 97 Claimant's Signature Christopher L. Kenney

97FEB-3 AM 10:39

RECEIVED-IHI-417

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date

4-4

19

97

Claimant's Signature

Christopher L. Kump

97 APR -7 AM 10:22

RECEIVED-INT-417

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date

5-6

19 97

Claimant's Signature

Christopher Kearney

RECEIVED - IHI-117
97 MAY -8 AM 10:37

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 6-2, 1997 Claimant's Signature

Theresa Keating

97 JUN -4 AM 9:10
RECEIVED - INT - 417

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information; I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 7-14, 19 97 Claimant's Signature [Signature]

RECEIVED - HT-417
JUL 14 AM 9:42

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 8-6, 19 97 Claimant's Signature Christine K...

RECEIVED-INT-417
97 AUG 12 AM 10:05

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date

8-26

19 97

Claimant's Signature

Christoph King

RECEIVED - IHI-917
97 AUG 28 AM 10:15

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 9-12-97 19 97 Claimant's Signature Christopher J. Keenan

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 10-29-97, 19__

Claimant's Signature

Christopher L. Kung

08:11 AM 4-NOV-97

RECEIVED-INT-417

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 11-29, 19 97 Claimant's Signature Christopher Keeney

97 DEC -1 PM 12:14

RECEIVED-INT-417

1066

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization:

Date 1-2

19 98

Claimant's Signature

Christopher L. Kearney

52:01WA S-AM 10:25

RECEIVED-INT-417

1068

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 2-2, 19 98 Claimant's Signature Christopher Keeney

RECEIVED-1HI-417
10-01 AM 10:01

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is/are entitled to receive a copy of this authorization.

Date 3-02

19 98

Claimant's Signature

Christoph Kearsy

70-1111 4-111186

111-111-111111

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date 4-1 19 98 Claimant's Signature Whitney King

98 APR -6 AM 9:21

RECEIVED-INT-417

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date

5-1

19

98

Claimant's Signature

Christopher L. Ramsey

RECEIVED - INT-177
MAY - 7 AM 8:34

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date

6-2

1998

Claimant's Signature

Christopher Kearney

98 JUN -5 AM 8:42

RECEIVED-THI-417

Disclosure Authorization

For purposes of this claim, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person, that has records or knowledge of my health, to give to the Jefferson-Pilot Life Insurance Company or any agent, attorney, consumer reporting agency or independent administrator acting on its behalf any such information. I hereby request and authorize Jefferson-Pilot Life Insurance Company to furnish all such information obtained by it to the policyholder's personal physician upon request and I hereby waive any privilege to such information. A copy of this authorization shall be as valid as the original. This authorization shall be valid for the duration of the claim.

I or my authorized representative is entitled to receive a copy of this authorization.

Date

7-1

19 98

Claimant's Signature

Christoph L. Keimig

86 JUL -8 AM 10:15

RECEIVED-INT-417

1080